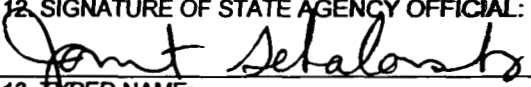
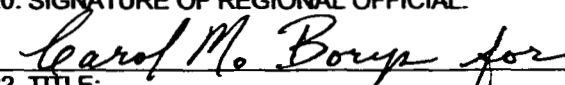


DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FOLLOWING ADMINISTRATION

Johnson (02-11)
Approved: 10/08/02
Effective: 01/01/03

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL HEALTHCARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: SPA #02-11	2. STATE: Kansas
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2003	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT a. FFY 2002 \$ 0 b. FFY 2003 \$ 50,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Replacement Page Attachment 3.1-A #9., Pages 1-2		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Replacement Page Attachment 3.1-A #9, Pages 1-2	
10. SUBJECT OF AMENDMENT: Dental Services			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Janet Schalansky is the Governor's <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Designee			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Janet Schalansky, Secretary Social & Rehabilitation Services Docking State Office Building 915 SW Harrison, Room 651S Topeka, KS 66612-2210	
13. TYPED NAME: Janet Schalansky			
14. TITLE: Secretary			
15. DATE SUBMITTED: August 19, 2002			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: OCT 8 2002	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Thomas W. Lenz		22. TITLE: ARA for Medicaid & State Operations	
23. REMARKS: SPA CONTROL Date Submitted: 08/19/02 Date Received: 08/21/02			

KANSAS MEDICAID STATE PLAN

Replacement Page
Attachment 3.1-A
#9., Page 1

Clinic Services Limitations

Ambulatory Surgical Centers

1. Ambulatory surgical center services are limited to procedures approved by the Division of Medical Programs. Only medically necessary surgical procedures are covered with the exception that elective sterilization procedures are covered.
2. Refer to limitations described in Attachment 3.1-A, #5 (Physician Services) and #10 (Dental Services).

Local Health Departments

1. Home health skilled nursing services.
 - a. Home health skilled nursing services are covered only if located in a county not served by a home health agency meeting Medicare requirements. With the following exception:
 - i. Home visit to the newborn. This home visit is limited to one per consumer within 28 days after the birth date of the infant and must be performed by a registered nurse.
 - b. Home health skilled nursing services require a plan of treatment developed by a physician, and certification by a physician that home health services are needed.
 - c. Home health skilled nursing services must be provided by a registered nurse.
 - d. Medical supplies include but are not limited to dressing materials, disposable syringes, colostomy supplies and catheter supplies.
2. Family planning services.
 - a. Initial family planning visits are limited to one per recipient.
 - b. Annual family planning visits are limited to one per 12 months.
 - c. Interim family planning visits are limited to three per 12 months.
3. The medical components of prenatal care are covered by designated local health departments.
4. Health promotion and risk reduction for pregnant recipients are limited to the following components:
 - a. Risk assessment by a nurse.
 - b. Confirmation of participation in or referral to prenatal care.
 - c. Report to medical provider of recipient's participation in the program.
 - d. Report to recipient on identified risks and suggested remedial measures.
 - e. Referral to appropriate support services.

OCT 18 2002

TN #MS #02-11 Approval Date _____ Effective Date 1/1/03 Supersedes MS #89-11

KANSAS MEDICAID STATE PLAN

**Replacement Page
Attachment 3.1-A
#9., Page 2**

Clinic Services Limitations

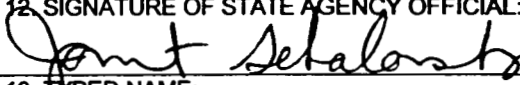
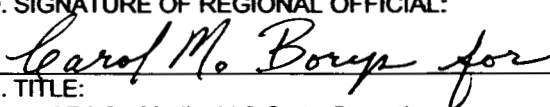
- f. Follow-up contact each trimester following initial contact.
 - g. Counseling and teaching in at least three face-to-face contacts.
 - h. Nutrition visits for pregnant women who meet nutrition risk criteria.
-
- 5. Laboratory services and immunizations are limited to a state agency-approved listing.
 - 6. Screening, diagnosis and treatment of sexually-transmitted diseases are covered, with the exception of testing for Acquired Immune Deficiency Syndrome which is free of charge.
 - 7. Nursing assessments must be performed by registered nurses.
 - 8. Dental services as described in 3.1-A, #10 - #11 and 3.1-A, #4.b., pages 4 & 5.
 - 9. See Attachment 3.1-A, #4.b., for Clinic services limitations for children under 21 years of age.

Maternity Centers

- 1. Maternity center services are limited to those provided by state-licensed centers.
- 2. Services are limited to normal labor and delivery.

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#9, Page 2**

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